Department of the Army
Pamphlet 600–63–9

Personnel—General

“Fit To Win” Hypertension

Headquarters
Department of the Army
Washington, DC
1 September 1987

UNCLASSIFIED

SUMMARY of CHANGE

DA PAM 600–63–9
“Fit To Win”
Hypertension

Not applicable.

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"Fit To Win" Hypertension

By Order of the Secretary of the Army:

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General, United States Army
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Brigadier General, United States Army
The Adjutant General

History. This publication has been reorganized to make it compatible with the Army electronic publishing database. No content has been changed.

Summary. Not applicable.

Applicability. This guidance applies to installation commanders and members of installation/community health promotion councils. This includes but is not limited to: Director of Personnel and Community Activities (DPCA); Director of Logistics (DOL); Public Affairs Officer (PAO); Chief, Family Support Division (FSD); Chief, Community Operations Division (COD); Commander, Medical Treatment Facility (MTF); Director, Plans, Training, and Mobilization (DPTM); Civilian Personnel Officer (CPO); Chief, Community Mental Health Service (CMHS); Chief, Community Relations Division (CRD); Alcohol and Drug Abuse Prevention Control Program (ADAPCP) Officer; Field Director, American Red Cross (ARC); Dietitian; Community Health Nurse (CHN)/ Nurse Practitioner.

Proponent and exception authority. Not applicable.

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Contents (Listed by paragraph and page number)

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Contents—Continued

I. Purpose.

This module is intended to provide general guidance regarding implementation, administration and evaluation of a High Blood Pressure Program at the installation level.

II. Applicability.

This guidance applies to installation commanders and members of installation/community health promotion councils. This includes but is not limited to: Director of Personnel and Community Activities (DPCA); Director of Logistics (DOL); Public Affairs Officer (PAO); Chief, Family Support Division (FSD); Chief, Community Operations Division (COD); Commander, Medical Treatment Facility (MTF); Director, Plans, Training, and Mobilization (DPTM); Civilian Personnel Officer (CPO); Chief, Community Mental Health Service (CMHS); Chief, Community Relations Division (CRD); Alcohol and Drug Abuse Prevention Control Program (ADAPCP) Officer; Field Director, American Red Cross (ARC); Dietitian; Community Health Nurse (CHN)/Nurse Practitioner.

III. Background.

a. High Blood Pressure (hypertension) contributes directly or indirectly to one million deaths per year. The term "Silent Killer" is used synonymously with high blood pressure since this condition may remain unnoticed in many individuals. It is a major cause of increased risk for stroke, heart attack and kidney disease. One out of four American adults is affected by high blood pressure. One out of three blacks has elevated blood pressure.

b. High blood pressure can be controlled but not cured. After an individual has been diagnosed as having hypertension, good nutrition, weight control, exercise and medication are considered part of a treatment regimen by a health care provider. Many deaths can be prevented if high blood pressure is detected early and managed properly.

c. The terms blood pressure and hypertension are synonymous and will be used interchangeably throughout this module. Increasing individual awareness through community education programs has been demonstrated to lessen the risks of this disease.

IV. Goals.

- Reduce incidence of undetected high blood pressure in Active Duty to zero by 1990.
- To provide public education so that 80% of the total Army family recognizes that uncontrolled High Blood Pressure is associated with stroke and heart disease.
- Integrate screening support services from the medical treatment facility into community based education programs.
- Conduct a community needs assessment and follow–up surveillance efforts on a continuing basis.

V. Responsibilities.

a. Commanders at all levels are responsible for the Hypertension Program implementation and the accomplishment of objectives, including the evaluation of the program and its impact within their organization.

b. The Health Promotion Council will, through coordinated efforts of the members, act as the central focal point for program information and advice to the Commander.

c. G3 or DPT will serve as a member of the Health Promotion Council and integrate education on hypertension in the training schedule.

d. Commander of the Medical Treatment Facility will monitor the health and aggregate lifestyle health risks in the command, provide technical consultation regarding education, information and intervention programs, and operate select hypertension programs requiring medical supervision.

e. The community health nurse will identify issues that impact on the overall program, act as liaison with civilian resources, assure that the program is integrated in the overall health promotion program, and coordinate assessment and evaluation efforts.

f. Staff Judge Advocate will provide advice and assistance regarding the legal ramifications of the hypertension program, policy and procedures.

g. The Civilian Personnel Officer will provide representation on the Health Promotion Council and assure that the local programs take into consideration the needs of the civilian work force.

VI. Module Elements.

The program is comprised of five areas:

A. Needs Assessment
B. Information
C. Education
D. Intervention
E. Evaluation

The program elements are on–going simultaneously and modified appropriately, based on periodic needs assessment and program evaluation.

Table 1
Suggested Elements for Level 1–2–3 Fit To Win Programs

Modules	Level 1 Program	Level 2 Program	Level 3 Program
Commander's Guide	Introductory Chapter Strategies for program management, and resources	Same as Level 1	Same as Level 1
Marketing	Unit briefings Post media Community needs assessment Posters, slides, videotapes Incentives. — Personal recognition certificates — Awards Evaluation Strategies	Level 1 plus: Guest speakers Promotional items	Level 2 plus Public relations campaigns Support groups Intramural competitions
Individual Assessment	Automated Health Risk Appraisal Health Risk Review Session	Same as Level 1	Same as Level 1
Physical Conditioning*	Community/unit based programs to include aerobic and strength development classes AR 350–15 Guidance National Fitness Month	Level 1 plus individualized prescription based on fitness evaluation	Same as Level 2
Procedures Guide	Pamphlets/Brochures/Posters Command Briefings (at least monthly) Incentive/Sustainment Program	Unit Training Schedules which reflect health promotion education classes in all areas needed	Unit Days for: Health Risk Assessment Family Health Promotion Activities
Nutrition and Weight Control	Pamphlets/posters brochures Media blitz for dining hall: menus National Nutrition Month AR 600–9 Guidance	Level 1 plus: Group classes Videotapes Slides/Cassette tape	Level 2 plus: Nutritional Assessment Individualized diet plans Computerized nutritional analysis Cooking classes
Antitobacco	Pamphlets/brochures Media blitz advice for smokers and nonsmokers National Smokeout AR 1–8 Guidance	Level 1 plus: Group cessation programs Videotapes Radio/TV spots	Level 2 plus: Computerized cessation program Support group
Stress Management	Pamphhlets/brochures Posters Welcome Packets with resources within the community Sponsorship Program associated with PCSs	Level 1 plus: Group classes Videotapes Radio/TV spots Commanders session's Unit training Community Skill/Activity Classes	Level 2 plus: Individual treatment programs conducted at medical Treatment Facility
Hypertension Management	Pamphhlets/brochures Unit level Monitoring National High Blood Pressure Month (May) Periodic B.P. checks/follow–ups	Level 1 plus: Group classes Videotapes TV, Radio spots	Level 2 plus: Individual counseling
Substance Abuse Prevention	Pamphlets/brochurs Posters Group meetings and classes AR 600–85 Guidance	Level 1 plus: Videotapes	Level 2 plus: Individual counseling Support groups
Spiritual Fitness	Pamphlets/brochurs Posters Opportunities to meditate, pray, or worship AR 165–20	Level 1 plus: Group meetings classes Developmental activities	Level 2 plus: Individual counseling Referral agencies Values building resources Support groups

Table 1
Suggested Elements for Level 1–2–3 Fit To Win Programs—Continued

Modules	Level 1 Program	Level 2 Program	Level 3 Program
Dental Health	Pamphlets/brochurs National Children's Dental Health Month Periodic Dental Examinations Unit Level Dental Fitness Classification Monitoring	Classes Videotapes Radio/TV spots Skills Classes	Individual Oral Hygiene Counseling Definitive Dental Treatment Long Term Follow–Up

Notes:
* Table 1 depicts an overview of the Fit To Win program. The program elements occur based on the Commander's resources and community needs.
* The exercise elements are the most likely to result in untoward events; therefore, cardiovascular screening must be required for all individuals 40 years of age and for anyone with a history of cardiovascular disease. A disclaimer is required.

a. Assessment.

(1) *Objective.* To determine the magnitude of the potential risk factors of high blood pressure in the community.

(2) *Strategy*

(a) Guidelines for community and individual needs assessment for high blood pressure are included in Annexes A and B. (Available with this module, but under separate cover is the Healthy Heart I. Q. questionnaire which was developed by the U.S. Department of Health and Human Services).

(b) Health risk appraisals contain questions which are valuable at targeting those who are at high risk for Hypertension. Those particularly at risk are:

- Excessive Drinkers
- Overweight Individuals
- Middle Aged Individuals
- Black and Oriental Ethnic Backgrounds
- Women Using Contraceptives

(c) The collected data can be used to begin, improve or expand a program. After determining the extent of the problem and the target groups in the greatest need, appropriate resources should be identified. Ideally, assessment is an on going process to ensure updated, realistic objectives.

Figure 1. Assessment

b. Information (Marketing).

(1) *Objective.* Heighten awareness in the Army Community to promote change in attitudes and consequently behaviors concerning hypertension.

(2) *Strategy.*

(a) The most important determinant of the success or failure of a high blood pressure control program is the positive and persuasive publicity about the health benefits of program participation.

(b) Characteristics of the target population should determine the nature of the program publicity and the types of media outlets to be utilized.

(c) Marketing a High Blood Pressure Program should focus on high blood pressure control and decreasing risk factors, rather than encouraging an increased load for screening at the Medical Treatment Facility.

(d) Various pamphlets, posters, technical information and planning resources may be obtained through the order form (attached under separate cover), from the High Blood Pressure Information Center.

c. Education.

(1) *Objective.* To create a positive image of the early identification and control of high blood pressure.

(2) *Strategies.*

(a) Guidelines for individual and community education strategies are listed at Annex D.

(b) Educational strategies should include an explanation defining high blood pressure.

d. Intervention.

(1) *Objective.* To provide preventive education and an optional screening program in the Army Community, while utilizing qualified individuals to evaluate individual blood pressure readings when necessary.

(2) *Strategies.*

- Individuals identified to have blood pressures outside of normal limits during the screening process, must be referred to health care professionals at a medical treatment facility for an appropriate follow up.
- A mechanism should be integrated into the screening process so individuals recognized as high risk can be monitored to assure a follow–up.
- If follow–up has not taken place, the process needs to be reevaluated to determine why a follow–up did not occur.

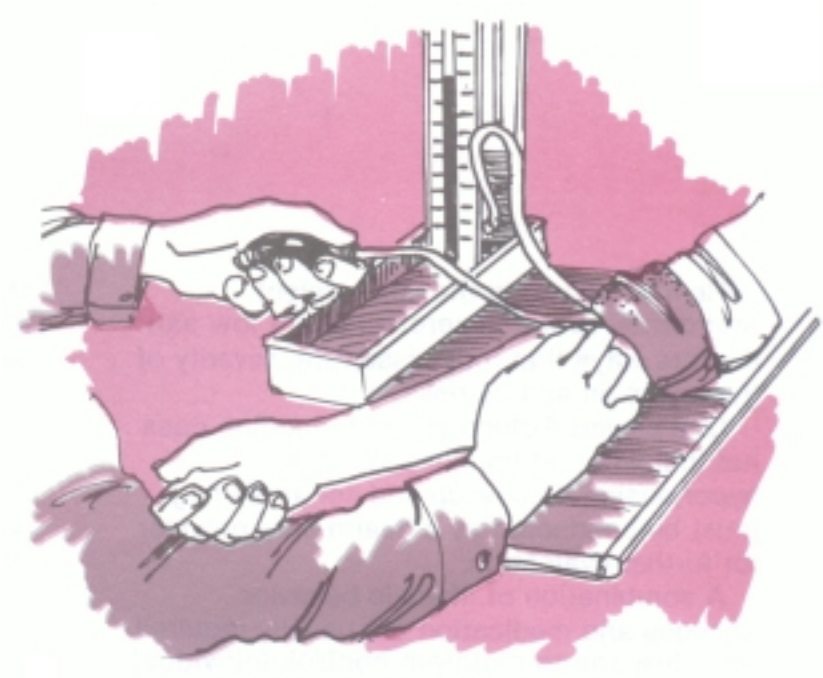

Figure 2. Intervention

e. Evaluation.

(1) *Objective.* To evaluate the effectiveness of educational and self–help hypertension programs on the values and beliefs of the Army family in order to reduce the risk of high blood pressure.

(2) *Strategies.*

(a) Methods of follow–up to be considered:

- Questionnaires
- Written Surveys
- Personal or Telephone Interviews

(b) Follow–up questionnaires, interviews over the telephone or in person, and/or written surveys, should be completed on any individual enrolled in formal classes for hypertension treatment.

(c) Information defining hypertension may be disseminated at this time.

(d) All prescreening publicity and educational efforts should be directed toward the overall goal of stimulating interest in the High Blood Pressure Screening Program.

(e) Remaining within the ideal weight standards, routine exercise, and a low salt diet are ways that may lessen the severity of hypertension and its risks.

(f) One elevated blood pressure reading does not indicate that an individual has hypertension. Follow–up and serial readings must be conducted by a health care provider for further evaluation.

(g) A combination of lifestyle behavior changes and medication are usually required for a lifetime to maintain control. Individuals should be educated and supported in maintaining appropriate therapy as directed by their health provider.

(h) For post wide evaluation, the Community Needs Assessment located in the Marketing Module or the survey listed at Annex A, can be readministered to measure changes in hypertension parameters for the local installation.

(3) *Process Evaluation.* A process evaluation can be obtained by keeping accurate records on the "Who, What, When, Where, and How" of the program from start to finish.

(4) *Outcome Evaluation.* An outcome evaluation can be made using results of how the program objectives were attained, e.g. periodic reports summarizing the progress of individuals in risk reduction.

Figure 3. Evaluation.

Appendix A
Items For Community Hypertension Assessment (Annex A)

Suggested questions for community wide hypertension assessment.

A–1. Who needs services?

- What is the prevalence of high blood pressure in the community?
- How many people are diagnosed hypertensive?
- How does this compare with national estimates?
- What is the prevalence for special populations (individuals considered hard to reach, at high risk, or within organized settings)?

A–2. What services are needed?

- What step(s) in the control process should be dealt with by the new or expanded program?
  - — Services are being offered for which steps?
  - — What portion of the target group is being served at each step?
- What services are currently being offered?
- To what extent are the needs of the groups being met by existing services?
- What new services need to be implemented?

A–3. Where should services be offered?

- Where are services currently offered?
- Are they accessible to groups to be served?
- What form of transportation does the target audience have/use to access services?
- Is there a geographical area where the target population lives and/or works that is not being served?
- What coordination/cooperation exists between service programs?

A–4. How should services be offered? Who should offer them?

- How are services delivered at each phase of the control process? By whom?
- What personnel facilities and resources are currently being used to offer services?
- What personnel/facilities are available?

A–5. US Department of Health & Human Services, PHS, NIH

Appendix B
Estimating Prevalence of High Blood Pressure (Annex B)

B–1. Your Installation's/Community's Response.

a. High blood pressure is not an isolated disease entity, but an affliction of individuals who may live on any installation. It is in these installations, with installation leadership, that high blood pressure must be detected. Local installations must accept the challenge to find and effectively treat the 10 to 30 percent of their own population who are hypertensive. Installations also must plan and implement specific high blood pressure control strategies for target populations. It is important that each installation implement appropriate, but not necessarily unique, high blood pressure control measures.

b. To help you conceptualize the problem facing your installation, the following formula (using national averages) will allow you to calculate approximate statistics for your installation.

• Assuming that approximately 2/3 (66 percent) of your population are adult (over age 18), figure as follows:	_____ × .66 _____	(total population) (adult population)
• Assuming that approximately 1/7 (15 percent of your adult population has high blood pressure, figure as follows:	_____ × .15 _____	(adult population) (HBP population)
• Assuming that approximately 3/10 (30 percent) of your HBP population are unaware they have HBP, figure as follows:	_____ × .30 _____	(HBP population) (unaware HBP population)
• Assuming that approximately 1/4 (25 percent) of your HBP population is aware but not being treated (at this point in time), figure as follows:	_____ × .25 _____	(HBP population) (aware, but untreated HBP population)
• Assuming that approximately 1/5 (20 percent) of your HBP population is treated but inadequately controlled, figure as follows:	_____ × .20 _____	(HBP population) (HBP population uncontrolled)

Figure B–1. Estimating Prevalence of High Blood Pressure

Summarize the above calculations in the chart below.

Summary

Estimated HBP Problem In Your Community	Challenge
• Unaware HBP population: ⟶	Correctly detect unaware HBP population
• Aware, but untreated HBP population: ⟶	Initiate correct HBP therapy for untreated HBP population
• Treated, but inadequately controlled HBP population: ⟶	Maintain correct HBP therapy for treated HBP population

To make one final estimate, calculate the number of people with HBP who are currently under control.

• Assuming that approximately 3/10 (30 percent) of your HBP population are adequately controlled, figure as follows:

_____ (HBP population)

× .30

_____ (HBP population controlled)

US Dept of Health, Education & Welfare, PH, Nat'l Heart, Lung & Blood Institute

Figure B–1. Estimating Prevalence of High Blood Pressure—Continued

B–2. Title not used.
Paragraph not used.

Appendix C
Marketing Hypertension Information (Annex C)

C–1. Marketing Hypertension Information.
a. In addition to the marketing information found in the Marketing Module of the "Fit To Win" package, other suggestions for disseminating high blood pressure information are as follows:

(1) Promote distribution of information relevant to specific population groups. (Level 1)

(a) Ethnic Groups. (Blacks, Orientals)

(b) Pregnant Women

(c) Those with identified risks

- Heart Disease
- Diabetes
- Kidney Disease

- Obesity
- Smokers
- Those in high stress jobs, etc.

(2) Disseminate general information regarding nature of health risks of controlling/reducing hypertension. (Level 1)

(a) In 90% of all individuals with high blood pressure, the cause is unknown.

(b) High blood pressure is termed the "Silent Killer" because there are usually no symptoms.

(c) High blood pressure cannot be cured, but it can be controlled through diet, weight loss, exercise and medication.

(d) Early detection of high blood pressure lessens the risk of stroke, heart attack and kidney disease.

(e) Hypertension (high blood pressure), is not a nervous disorder. One may still be relaxed or calm and have high blood pressure.

(f) High blood pressure can be determined by a quick, painless measure using a blood pressure cuff and stethoscope. (Level 2)

(3) Disseminate information through posters, flyers, news briefs, pay vouchers, and quarterly service advancements utilizing the national slogan for high blood pressure screening, "Know Your Numbers." (Level 1)

(4) Support the annual "National Hypertension Month," in cooperation with the National Center For High Blood Pressure each May. (Level 1)

(5) Utilize public service announcements on closed circuit television and radio; utilize Armed Forces Network resources and local papers. (Level 2)

(6) Provide periodic giveaways or "Attention getters" such as, buttons, stickers and T–shirts, using the slogan, "Know Your Numbers". (Level 1–2) These promotional devices may be used during community activities to include volksmarches, runs and sporting events.

b. Paratext not used.

C–2. Implementation Strategy Development.

1. Clearly specify the activity (who does what for whom).
2. Be sure someone is responsible for the entire activity and coordinates individuals who may carry out the different tasks.
3. Identify all the preparatory steps prior to doing that activity (e. g., prepare materials, write articles, acquire equipment, train volunteers, prepare training manuals, determine the treatment protocol).
4. List steps in the order in which they must occur.
5. Check for missing steps which need to be added.
6. Determine when (date) each step should begin and end.
7. Check your dates to make sure the correct amount of time has been allowed.
8. Consult with organizations affected by the activity; identify potential problems, opportunities, etc.
9. Specify what resources will be needed and state each source.
10. Specify what constraints will need to be addressed.
11. Make sure all people participating know what is expected of them and by when.

C–3. US Dept of Health, Education, and Welfare, PHS, Nat'l Heart, Lung and Blood Institute Activity and Implementation Strategy

Activity and Implementation Strategy

Activity: _____

Resources (to be used): _____

Constraints (to be addressed): _____

Figure C–1. Activity and Implementation Strategy

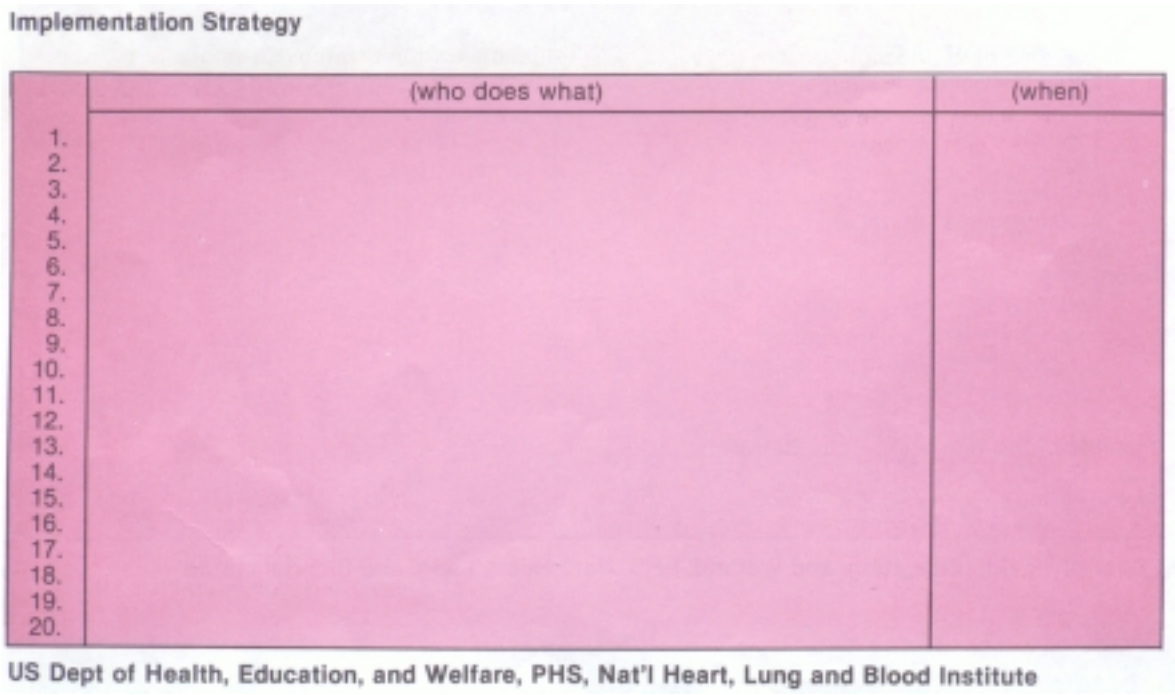

Figure C–1. Implementation Strategy

C–4. Resource Identification.

Table C–1
Resource Identification

People:	
sponsors or Supporters	
providers of service	
leaders	
staff skills and time:	
medical	
organizational	
planning	
clerical	
educational	
analytical	
Equipment:	
tables, chairs, etc	
BP devices	
lab equipment	

Table C–1
Resource Identification—Continued

data processing equipment	
typewriters, calculators, etc	
filing cabinets	
Supplies and materials:	
paper, pens, etc	
pamphlets	
posters	
forms	
a/v materials	
medication, lab supplies	
Information:	
HPB and its consequences	
community health care system	
status of HBP control in community	
community resources	
Facilities: (use, alterations, alternatives)	
Money: (for any of the above)	

Appendix D
Education (Annex D)

D–1. Education

a. According to statistics of the American Heart Association, worksite high blood pressure screening programs have a proven record for high participation. Lifesaving results have been noted in previous programs due to the highest interest level.

(1) *Training.* Provide general information classes regarding health risks of high blood pressure in the unit training schedule. (Level 2)

(2) *Command Information Briefs.* Disseminate information briefs suitable for use by personnel in leadership positions, highlighting the Army–wide effort in hypertension prevention. (Level 1)

(3) *Classes.*

(a) Provide high blood pressure information for the community through closed circuit television (where available) or at a monthly "Health Promotion Night." (Level 2–3)

(b) Other class topics include:

- Shaking the salt habit — (Reduce Salt intake)
- The Health effects of Cigarette Smoking
- Cholesterol: The Good and the Bad (HDL + Cholesterol)
- Weight Reduction
- Exercise and its Benefits
- Label Reading
- Food Preparation

The following educational tools are only suggestions. Additional information is enclosed under separate cover.

(4) *Posters* — American Heart Association (Level 1):

(a) "Watch Both Kinds of Hazards"

(b) "Keep Your Figures Under Control"

(c) "Keep Fit and Trim"

(d) "Scale Down to a Lower Blood Pressure"

(e) "Take Your Pills Along"

(5) *Pamphlets* — American Heart Association (Level 1):

(a) "What Every Woman Should Know About High Blood Pressure"

(b) "Remove Your Risk of Heart Attack"

(c) "High Blood Pressure Facts You Need to Know"

(d) "High Blood Pressure I. Q." (payroll insert)

(e) "So What's a Little Fat?" (payroll insert)

(6) *Films* — American Heart Association (Level 2):

(a) "High Blood Pressure: What it is, What it Can Do to You"

(b) "Feeling Fine": (For the 50 Years and Older Group)

(c) "High Blood Pressure: If Only it Hurt a Little"

(7) *Displays* — Posters and pamphlets should be displayed in areas frequented by the total Army Family: Suggested areas could include:

(a) Bulletin Boards

(b) Cafeteria displays

(c) Banks

(d) Post Exchanges

(e) Commissary, etc.

(8) **Speakers** should be scheduled at times and places convenient to community members. A planned lunchtime lecture series or working demonstration may help to maintain a community interest in the high blood pressure program. (Level 2–3)

b. Paragraph not used.

D–2. Title not used.

Paragraph not used.

Appendix E
References/Resources

E–1. Bibliography/References

Community Guide to High Blood Pressure Control (NIH Pub. #82–2333)
U.S. Dept. of Health and Human Services
National Institute of Health
High Blood Pressure Program/Coordinator's Guide
American Heart Association
7320 Greenville Ave.
Dallas, TX 75231
A Handbook for Developing Community and Worksite High Blood Pressure Programs
Preventable Diseases Division
State of Connecticut Dept. of Health Services
Printed Aids for High Blood Pressure Education
(NIH Pub. #85–1244)
U.S. Dept. of Health and Human Services
National Institute of Health
Blood Pressure Control at the Worksite
Institute of Labor and Industrial Relations
University of Michigan — Wayne State University
Put the Effects of High Blood Pressure Out of Business
New York State Dept. of Health
Empire State Plaza
Albany, NY 12237
National High Blood Pressure Education Program
National Institute of Health
Bethesda, MD 20205
(703) 558–4880

E–1. Title not used.

Paragraph not used.

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